Microchanneling Screening Form

BOLD RED items are hard contra-indication

Name: _____ Date: _____

Address: _____

City: _____ St: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Referred by: _____

Yes	No	Are you over 18 years of age?
Yes	No	Do you take aspirin or blood thinners regularly?
Yes	No	Have you had injectables in the past 30 days?
Yes	No	Have you taken any mood altering drugs in the past 8 hours?
Yes	No	Do you have a history of cold sores, herpes or fever blisters?
Yes	No	Are you sensitive to Latex?
Yes	No	Have you had a chemical or LASER peel? If so, when? _____
Yes	No	Do you have trouble healing?
Yes	No	**Are you currently undergoing radiation or chemotherapy?**
Yes	No	Are you currently using Retin-A, AHA, or other exfoliating skin care products?
Yes	No	Are you allergic to any metals?
Yes	No	Are you currently taking anti-inflammatory medications or steroids?
Yes	No	Are you allergic to any anesthetics, (any of the “caines”)?
Yes	No	Do you have a history of skin disease?
Yes	No	Do you have a history of skin sensitivity?
Yes	No	Are you currently taking vitamin A or E in any form?
Yes	No	**Are you pregnant or nursing?**
Yes	No	Are you currently being treated by a dermatologist?

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	Compromised Immunity	**Accutane in last 2 yrs**
Allergic to Steel	**Diabetes (uncontrolled)**	**Chronic Skin Disease**	**Hemophilia**

_____

Microchanneling Consent Form

Patient name:_____**Date:** _____

I authorize _____to perform ProCell Microchanneling on my skin, and to apply topical preparations as determined necessary.

I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising, and temporary discoloration of the skin, as well as rare side effects such as infection & scarring. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post-treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and that the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes, and possible complications, and I understand that no guarantee can be given as to the final result obtained and that there are no refunds offered for lack of satisfactory results. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and “not do” before, during, and after the procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education, and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein and hold harmless from any and all claims, demands, liabilities, judgments, costs, and expenses arising out of any claims relating to the procedure authorized herein.

Signature: _____Date: _____

Microchanneling Treatment Chart

Patient name:_____

Date	Areas	Needle Depths	# Passes

Recommendations for Future Treatment:

_____

• **Post care information given**

Notes:

_____

_____

Practitioner Sign Off:

Signed: _____Date: _____

Signed: _____Date: _____

Signed: _____Date: _____

Signed: _____Date: _____

Signed: _____Date: _____

Signed: _____Date: _____